

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

M

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
10238														
10197														
1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CECIL</u> ✓									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>			c. LENGTH OF STAY in 1b <u>2 mo.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ES. STATE HOSP</u>					d. STREET ADDRESS <u>102 Elkton Blvd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>DOUGLAS J. AYERST</u>					4. DATE OF DEATH Month Day Year <u>9 - 10 1960</u>									
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/4/67</u>		9. AGE (In years last birthday) <u>93</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SUPT.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PULP MILL</u>		11. BIRTHPLACE (State or foreign country) <u>CANADA</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>ALFRED AYERST</u>					14. MOTHER'S MAIDEN NAME <u>MARY TODD</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>—</u>					17. INFORMANT Address <u>RECORDS E.S.S.H. CAMBRIDGE</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>9027</u> <u>TERMINAL PNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>FRACTURE NECK FEMUR</u> DUE TO (c) <u>6 DAYS</u>										2 DAYS				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>SLIPPED AND FELL ON PERCH</u>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>11:30</u> <u>9-4-60</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HOSPITAL</u>		20f. (City or town) <u>CAMBRIDGE</u>		(County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <u>John Mace Jr</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) <u>JOHN MACE JR</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <u>9/10/60</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>9/14/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>			22d. LOCATION (City, town, or country) (State) <u>Elkton, Md.</u>				
23. FUNERAL DIRECTOR <u>Ralph E. Hicks, Elkton, Md.</u>					ADDRESS		24a. REC'D BY REGISTRAR <u>SEP 13 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u>					

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10239 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10198

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN b 5 mo. 23 das d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eastern Shore State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sharptown d. STREET ADDRESS 4th St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Malona Middle Wright Last Bailey		4. DATE OF DEATH Month September Day 14 Year 1960	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-19-74
9. AGE (In years last birthday) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Wright	
14. MOTHER'S MAIDEN NAME Jane Phillips		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. 216-03-5081		17. INFORMANT Address Records-Eastern Shore State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Terminal pneumonia 904.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture neck left femur. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 wk. 5 Mo.
18a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell in home.	
20c. TIME OF INJURY Month, Day, Year 3-15 19 60 Hour a.m. 3 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Sharptown (County) Wi. (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr. EXAMINER'S NAME (Type) John Mace Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 9/15/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-17-60	22c. NAME OF CEMETERY OR CREMATORY Taylors	22d. LOCATION (City, town, or country) (State) Sharptown, Md.
23. FUNERAL DIRECTOR Smith Funeral Home ADDRESS Sharptown, Md.		24a. REC'D BY REGISTRAR SEP 23 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

MEDICAL CERTIFICATION

1958

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1958

1958

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10199

10220

Item 7 - 11106211 9-29-60 et

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Dorchester, Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester, Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 094 Glenburn Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Evelyn Proctor Black				4. DATE OF DEATH Month Day Year 9 15 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown	
9. AGE (In years last birthday) About 98		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper				10b. KIND OF BUSINESS OR INDUSTRY House Keeper		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Marcillars Proctor				14. MOTHER'S MAIDEN NAME Bessie Proctor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. No			
17. INFORMANT Address Mr. Victor J. Black, Airys, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Anteriosclerotic Nephritis 5 days (b) Anteriosclerotic Heart Disease 2 yrs (c) lying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/10 1960 to 9/14 1960 that (I) (we) last saw the deceased alive on 9/14 1960 and that death occurred at 10:30 AM from the causes and on the date stated above.							
22a. SIGNATURE Lawrence Maryanov M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Lawrence Maryanov				22d. ADDRESS 136 Race St. Cambridge, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/17/1960.		23c. NAME OF CEMETERY OR CREMATORY East New Market Cemetery		23d. LOCATION (City, town, or county) (State) East New Market, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Md.				25a. REC'D BY REGISTRAR SEP 22 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

MEDICAL CERTIFICATION

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10240

CERTIFICATE OF DEATH

Reg. Dist. No.

10200

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East New Market</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East New Market</u>	
c. LENGTH OF STAY IN 1b <u>All life</u>		d. STREET ADDRESS <u>1 Main</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Estella Hester Blake</u>		4. DATE OF DEATH <u>7/28</u> 19 <u>60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/11/1880</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTH PLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George E. Hestley</u>		14. MOTHER'S MAIDEN NAME <u>Hester Hackett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. James Hatter</u>		Address <u>East New Market</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL ARTERIO SCLEROSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>334X</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>5 YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>25 APRIL 1958</u> to <u>28 SEPT 1960</u> , that I last saw the deceased alive on <u>27 SEPT 1960</u> , and that death occurred at <u>8:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. E. Gunby Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>105 Church St</u> DATE SIGNED <u>30 OCT '60</u>	
PHYSICIAN'S NAME (Type) <u>W. E. GUNBY JR.</u>		<u>Cambridge Ind.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>10/1/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>	22d. LOCATION (City, town, or county) (State) <u>Ind</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kathleen Kelly</u>		ADDRESS <u>East New Market</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
DATE <u>OCT 5 '60</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10520

W. E. GUNTER JR. *W. E. Gunter Jr.*
105 Church St. *105 Church St.*
300.10 *300.10*

10221

CERTIFICATE OF DEATH

10201

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland Hospital</u>		e. STREET ADDRESS <u>Maces Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>Moore</u> Last <u>Braxton</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>10</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 18, 1908</u>
9. AGE (In years last birthday) yrs. <u>52</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harrison Moore</u>		14. MOTHER'S MAIDEN NAME <u>Isabell Moore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>230-12-5148</u>	
17. INFORMANT <u>Arkelga Braxton, Cambridge, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Heart Disease</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral Bronchopneumonia</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 6, 1960</u> to <u>Sept 10, 1960</u> , that I last saw the deceased alive on <u>Sept 10, 1960</u> , and that death occurred at <u>M, from the causes and on the date stated above.</u> ADDRESS (Street, city or town, state) <u>227 Pine St-Cambridge, Md.</u> DATE SIGNED <u>9-13-60</u>			
ACTUAL SIGNATURE <u>J. Edwin Fassett</u>		M.D. <u>227 Pine St-Cambridge, Md.</u>	
PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Rem-Burial</u>		22b. DATE THEREOF <u>9/15/1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Ceme.</u>		22d. LOCATION (City, town, or county) (State) <u>Rehobeth, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. House</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 15 '60</u>	
ADDRESS <u>Cambridge, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1931

Blank certificate form with horizontal lines for text entry.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10202

FOR STATE
HEALTH DEPT.

10241

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>DOR</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE MD</u>	
c. LENGTH OF STAY IN 1b <u>2 yrs</u>		d. STREET ADDRESS <u>LINDEN AVE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ESS HOSP.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>STEVENS</u> Last <u>BULL</u>		4. DATE OF DEATH Month <u>9</u> Day <u>12</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/18/1875</u>
9. AGE In years <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARE TAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALL PARK</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JAMES BULL</u>		14. MOTHER'S MAIDEN NAME <u>JULIA DAVIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>RECORDS ESS.H. CAMBRIDGE</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>COLLES FRACTURE FRACTURE METACARPAL</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>SLIPPED + FELL ON FLOOR</u>	
20c. TIME OF INJURY Hour <u>6</u> a.m. <u>30</u> Month <u>9</u> Day <u>12</u> Year <u>1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HOSPITAL</u>		20f. (City or town) (County) (State) <u>CAMBRIDGE MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr</u>		DATE SIGNED <u>9/12/60</u>	
EXAMINER'S NAME (Type) <u>JOHN MACE JR</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Sept 14 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>East New Market Md</u>		22d. LOCATION (City, town, or county) (State) <u>East New Market Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. H. Mellowhy</u>		24a. RECORDS REGISTRAR <u>SEP 16 1960</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>		24c. DATE <u> </u>	



10222 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10203

FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

DEPUTY FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. Its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VS. A15ME
5M 7/59

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY Dorchester		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		a. STATE Maryland		b. COUNTY Dorchester	
c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		d. STREET ADDRESS 208 Locust Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) High Street		3. NAME OF DECEASED (Type or print) Frederick Henry Christopher		4. DATE OF DEATH Month Day Year Sept. 1, 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 23, 1881	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Farm Mechanic		11. BIRTHPLACE (State or foreign country) Maryland		9. AGE (in years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 78 yrs. Months Days Hours Min.	
13. FATHER'S NAME Frederick Christopher		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs Jean Stettbacher		Address Cambridge Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Mace Jr.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/1/60	
EXAMINER'S NAME (Type) John Mace Jr.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 3, 1960		22c. NAME OF CEMETERY OR CREMATORY East New Market Cem/		22d. LOCATION (City, town, or country) (State) East New Market Maryland	
23. FUNERAL DIRECTOR Le Compte Funeral Service		ADDRESS Cambridge Maryland		24a. REC'D BY REGISTRAR SEP 7 '60		24b. REGISTRAR'S SIGNATURE Anthony S. House	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any change is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

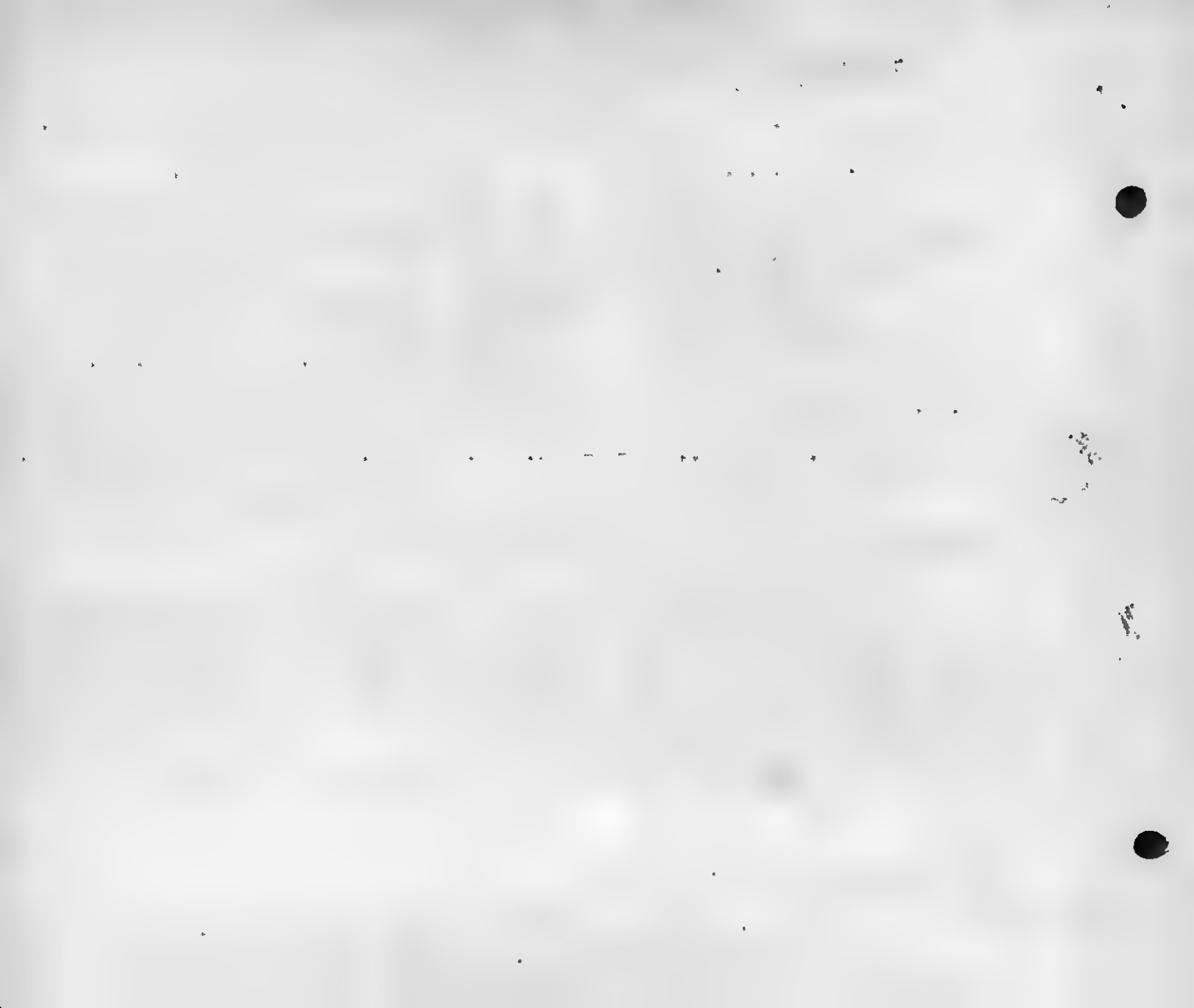
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10242

10204

1. PLACE OF DEATH a. COUNTY <u>Dorchester, Co.</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>East New Market, R.F.D.</u> <u>3 Years</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>None</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester, Co.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>East New Market, Maryland.</u> d. STREET ADDRESS <u>None</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James V. Cooney</u> First Middle Last 4. DATE OF DEATH <u>9 10 1960</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>6/2/1899</u> 9. AGE (in years (if UNDER 1 YEAR last birthday) IF UNDER 24 HRS. Months Days Hours Min. <u>61</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Army</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Army</u> 11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Leo. J. Cooney</u> 14. MOTHER'S MAIDEN NAME <u>Anna May</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>176-32-1401</u> 17. INFORMANT <u>Mrs. James v. Cooney, East New Market, Md.</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Instant</u> DUE TO (c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a. <u>420.1</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>9/13/60</u> DATE SIGNED Address (Street, city, town, or country) (State)		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>9/14/1960.</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery, Arlington, Va.</u> 22d. LOCATION (City, town, or country) (State) 23. FUNERAL DIRECTOR <u>Le Compte Funeral Service, Cambridge, Md.</u> 24a. RECORDED BY REG. STRAUS 24b. REGISTRAR'S SIGNATURE <u>SEP 22 '60</u> <u>Arthur S. Straus</u>	

MEDICAL CERTIFICATION

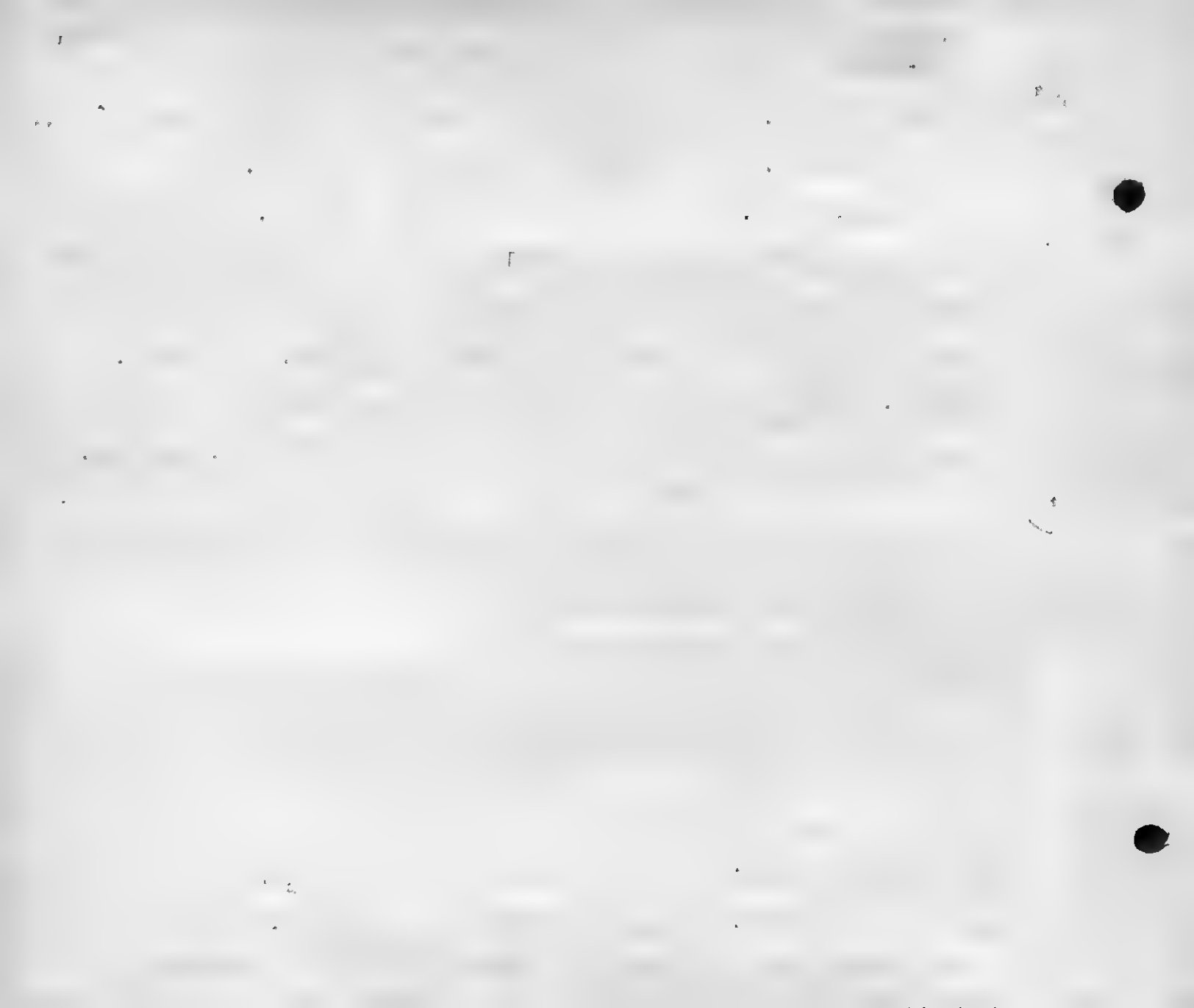


TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and to any event within 72 hours after death.

VS. A15ME
SM 7/59

1
FOR STATE HEALTH DEPT. M
10223
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
10205

1. PLACE OF DEATH a. COUNTY <u>Dorchester, Co.</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Maryland.</u> c. LENGTH OF STAY IN 1b <u>68 Years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>203 Academy, Street.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester, Co.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Maryland.</u> d. STREET ADDRESS <u>203 Academy, Street.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ida Abbott</u>		4. DATE OF DEATH <u>9 21 1960</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/25/1872</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Elliott, Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Damuel J. Abbott</u>		14. MOTHER'S MAIDEN NAME <u>Philistine Langrall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mr. Lee Abbott</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 20. DUE TO <u>20 min.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>20 min.</u> DUE TO <u>20 min.</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) <u>20 min.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>9 23 1960</u> Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED <u>White</u> <input type="checkbox"/> <u>Not White</u> <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
21. ACTUAL SIGNATURE <u>John Ace Jr.</u> M.D.		21. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>9/22/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/23/1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cambridge Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Cambridge, Maryland.</u>	
23. FUNERAL DIRECTOR <u>Le Compte Funeral Service, Cambridge, Maryland.</u>		24a. REC'D BY REGISTRAR <u>SEP 29 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>	



10243

CERTIFICATE OF DEATH

10206

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>QUEEN ANNE</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CENTREVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSPITAL</u>		d STREET ADDRESS	
3 NAME OF <u>NINA V. DRAPER</u> (Type or print) First Middle Last		4. DATE DEATH <u>SEPTEMBER 12 1960</u> Month Day Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 12 1894</u>
9 AGE (In years last birthday) <u>76</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PUBLIC SCHOOLS</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>ROBERT FRANCIS HANE</u>		14. MOTHER'S MAIDEN NAME <u>SALLIE HARWOOD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL HEMORRHAGE</u> DUE TO (c)		INTERVA. BETWEEN ONSET AND DEATH <u>4 HOURS</u> <u>24 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>AUGUST 1, 1958</u> to <u>SEPT. 12, 1960</u> that I last saw the deceased alive on <u>SEPTEMBER 12 1960</u> , and that death occurred at <u>12:00</u> p.m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Harry J. Crawford</u>		M.D. <u>EASTERN SHORE STATE HOSPITAL</u> <u>SEPT 12, 1960</u>	
PHYSICIAN'S NAME (Type) <u>HARRY J. CRAWFORD</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 14 - 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Centerville</u>	22d. LOCATION (City, town, or county) (State) <u>Centerville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William S. Smith</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 20 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59



7

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10224

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10207

Item 8 filed 271 9 19 60 et

1 PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If not at an Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Tackett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Royal Oak</u>	
c. LENGTH OF STAY IN 1b <u>6 days</u>		d. STREET ADDRESS <u></u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Md. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Phillip Henry Fiedlerman</u>		4. DATE OF DEATH <u>Sept. 9 1960</u>	
S. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Aug 23 1884</u>
9 AGE (In years last birthday) <u>74</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Relig. Supply Storeman</u>	
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Phillip Henry Fiedlerman</u>		14. MOTHER'S MAIDEN NAME <u>Mary Earl</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16 SOCIAL SECURITY NO <u>377-09-0766</u>	
17 INFORMANT <u>Mrs. P.H. Fiedlerman</u>		Address <u>Royal Oak Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumothorax, left</u> <u>5 cm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Healed tuberculosis</u> (c) <u>Medicinal shift to right</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
22a SIGNATURE <u>E.C.H. Schmidt</u>		22b DATE SIGNED <u>10 Sept. 60</u>	
22c PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>		22d ADDRESS <u>Easton, Maryland</u>	
23a BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		23d LOCATION (City, town, or county) (State) <u>Easton Md</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Easton</u>		25a REC'D BY REGISTRAR <u>SEP 14 '60</u>	
25b REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 and should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10225

CERTIFICATE OF DEATH

10208

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN lb <u>none</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Boy</u> Middle <u>Gabbin</u> Last <u>Gabbin</u>				4. DATE OF DEATH Month <u>September</u> Day <u>21</u> Year <u>19 60</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 20, 1960</u>		9. AGE (In years last birthday) <u>10</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>41</u>	IF UNDER 24 HRS. Hours <u>10</u> Min. <u>41</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baby</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Cambridge, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Edward Gabbin</u>				14. MOTHER'S MAIDEN NAME <u>Bernice Jackson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Mother <u>Taylors Island, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra Cranial Hemorrhage</u> <u>760.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cranial Trauma in birth canal</u> DUE TO (c) <u>Possible early hyaline membrane disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(Prematurity Wgt. 3lb. 11oz.)</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No prenatal care to mother</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 20</u> , 19 <u>60</u> , to <u>Sept. 21</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Sept. 21</u> , 19 <u>60</u> , and that death occurred at <u>2:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Eldridge H. Wolff</u> M.D.				ADDRESS (Street, city or town, state) <u>Cambridge, Maryland</u> DATE SIGNED <u>9-22-60</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Eldridge H. Wolff</u>				<u>15 Locust St. Cambridge, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		22b. DATE THEREOF <u>Sept. 22, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cambridge Maryland Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>SEP 30 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	

10226

CERTIFICATE OF DEATH

10209

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>30 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Phillips Street Ext'd</u>				d. STREET ADDRESS <u>Phillips Street Ext'd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mable</u> Middle <u>Geneva</u> Last <u>Gamby</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 15, 1908</u>		9. AGE (In years last birthday) yrs <u>52</u>	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Caroline County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>213-14-7804</u>		17. INFORMANT <u>George Gamby, Cambridge, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anemia, severe</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mitral valve ca. bones & lines</u> DUE TO (c) <u>Ca breast</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6-7 hours</u> <u>1 yr.</u> <u>3 yrs.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity, diabetes, hypertension</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1960</u> to <u>Sept 19</u> 19 <u>60</u> , that I last saw the deceased alive on <u>Sept 17</u> 19 <u>60</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. U. Thompson</u> M.D.				ADDRESS (Street, city or town, state) <u>Cambridge, Md</u> DATE SIGNED <u>Sept 30/60</u>			
PHYSICIAN'S NAME (Type) <u>J. U. Thompson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/21/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Waugh Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert H. H. H.</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 4 '80</u>	
				24b. REGISTRAR'S SIGNATURE <u> </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10227

CERTIFICATE OF DEATH

Reg. Dist. No.

10210

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 57 Douglas Street				d. STREET ADDRESS 57 Douglas Street			
3. NAME OF DECEASED (Type or print) First Middle Last Cornelia Henson Hayward				4. DATE OF DEATH Month Day Year Sept. 1, 1960			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 26, 1876	
9. AGE (In years last birthday) 84 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Henson				14. MOTHER'S MAIDEN NAME Harriett Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-07-9529			
17. INFORMANT Edmond Hayward, Cambridge, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cambridge, Maryland	
20f. (City or town) Cambridge				20g. (County) Maryland		20h. (State) Maryland	
21. I certify that I attended the deceased from January 1, 1959 , to XXXX Sept 1, 1960 that I last saw the deceased alive on Sept 1, 1960 and that death occurred at 1 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. Edwin Fassett				ADDRESS (Street, city or town, state) 227 Pine St-Cambridge, Md.			
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.				DATE SIGNED 9-3-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/4/1960		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE St. Clair Lewis				ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR SEP 14 '60	
				24b. REGISTRAR'S SIGNATURE William P. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be received by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

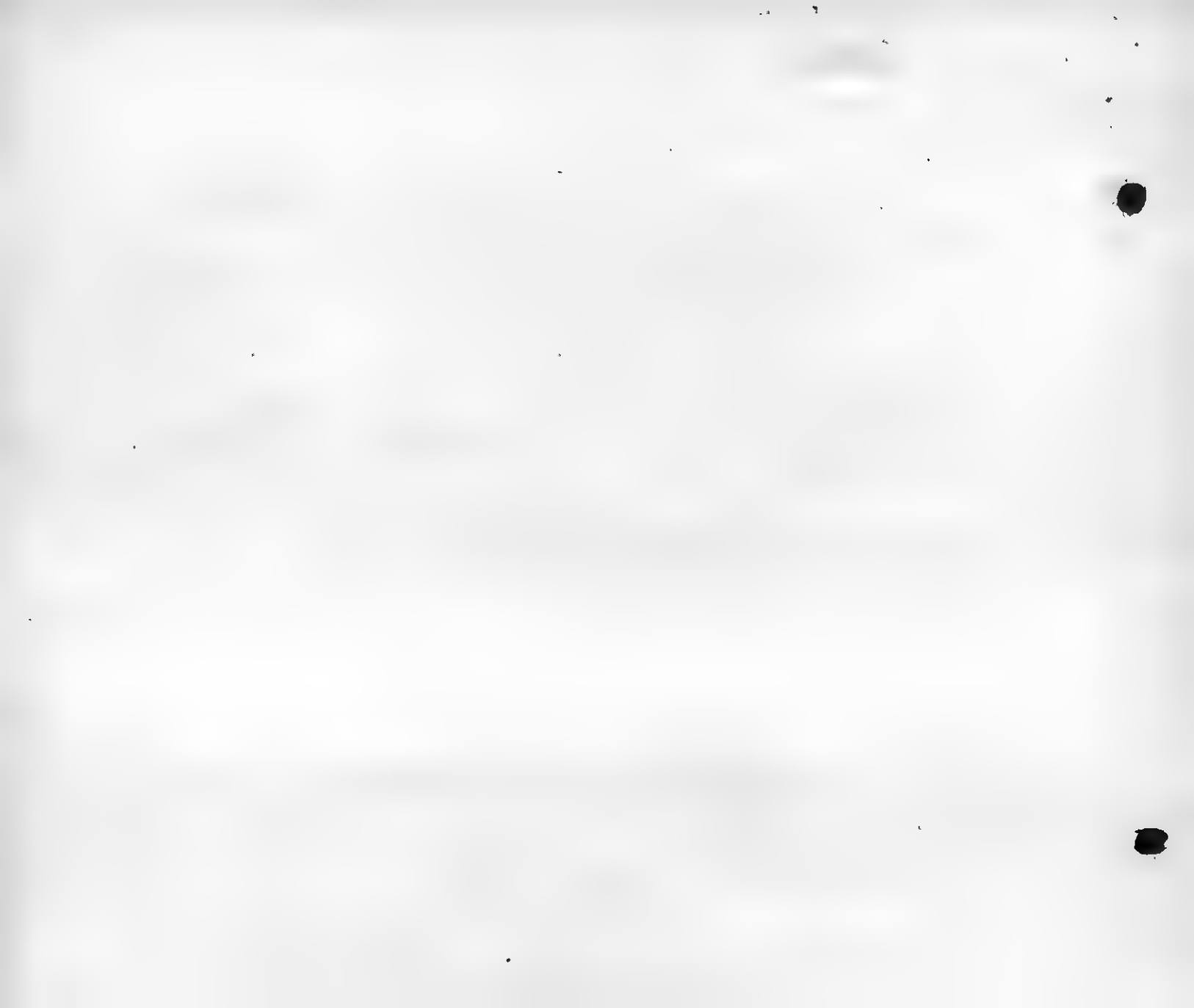
10228

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10211

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Res. dence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home		e. STREET ADDRESS 503 Brohawn Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Clyde Elmer Henry		4. DATE OF DEATH Month Day Year 9 16 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/20/1886
9. AGE (In years last birthday) 74 yrs		F UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Weaver		10b. KIND OF BUSINESS OR INDUSTRY Wire Cloth Mfg.	
11. BIRTHPLACE (State or foreign country) Dorchester County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Henry		14. MOTHER'S MAIDEN NAME Elizabeth Wheatley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W War I		16. SOCIAL SECURITY NO. 214 18 4463	
17. INFORMANT Maud Graham Henry, 503 Brohawn Ave., Camb., Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY ARTERY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/10/60 to 9/16/60 that (I) (we) last saw the deceased alive on 9/16 1960 and that death occurred at 12:00 M, from the causes and on the date stated above			
22a. SIGNATURE W. H. Hanks M.D.		22b. ADDRESS CAMBRIDGE Md 9/16/60	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-19-60	
23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		23d. LOCATION (City, town, or county) (State) Wilmington, Delaware	
24. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.		25a. REC'D BY REGISTRAR DATE SEP 22 '60	
25b. REGISTRAR'S SIGNATURE William S. Kenna			

Removed to: Smith & Wilson F.H., Wilmington, Del.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copy paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Hanks

10229

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10212

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7 Linden Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lester Middle M. Last Henry		4. DATE OF DEATH Month Sept Day 3 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27, 1906
9. AGE (In years lost birthday) yrs 54		10. IF UNDER 1 YEAR Months Days Hours Min 54	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Hauling		10b. KIND OF BUSINESS OR INDUSTRY Trucking	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John W. Henry		14. MOTHER'S MAIDEN NAME Amada Hurley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) No		16. SOCIAL SECURITY NO. 217 10 8521	
17. INFORMANT Mrs Lester Henry		Address Cambridge Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). Carcinoma Liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 12 weeks		INTERVAL BETWEEN ONSET AND DEATH 12 weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/12/1958 to 9/3/1960 that (I) (we) last saw the deceased alive on 9/3/1960 and that death occurred at 3:30 P.M. from the causes and on the date stated above.		22a. SIGNATURE W. H. Hanks, M.D.	
22b. DATE SIGNED 9/4/60		22c. ADDRESS CAMBRIDGE, MARYLAND	
23a. BLR AL. CREMATION. (Specify) Burial		23b. DATE THEREOF Sept 5, 1960	
23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		23d. LOCATION (City, town, or county) (State) Cambridge Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service		25a. REC'D BY REGISTRAR SEP 7 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Hanks			



TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

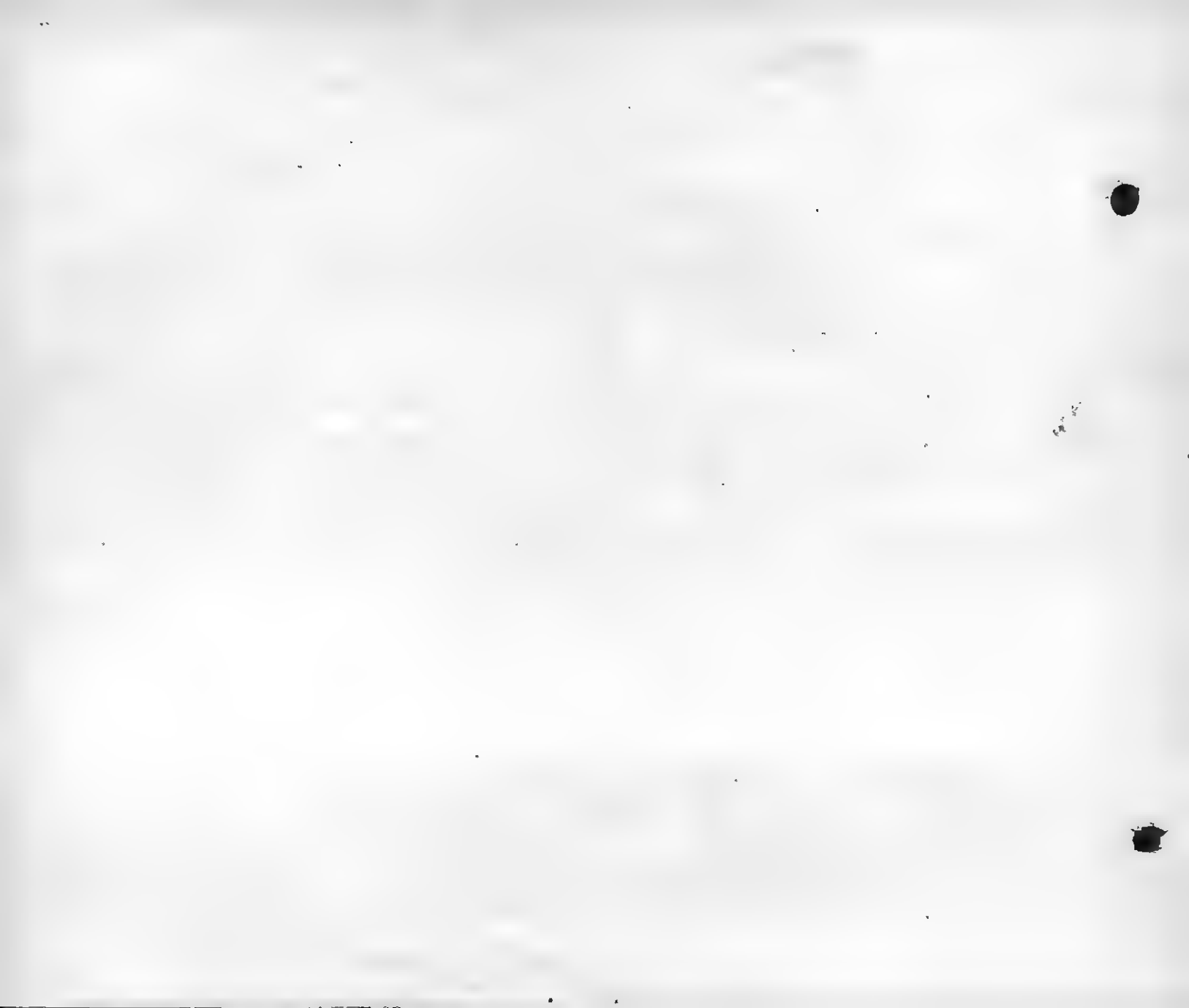
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10244

10214

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>24</u> days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS <u>-</u>	
3. NAME OF DECEASED (Type or print) First <u>Elmer</u> Middle <u>LOYD</u> Last <u>Hughes</u>		4. DATE OF DEATH Month <u>September</u> Day <u>26</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 24</u> <u>1887</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (If kind of work done during most of working life, even if retired) <u>Unknown Caretaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Golf Club</u>	
11. BIRTHPLACE (State or foreign country) <u>Unknown Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas J. Hughes</u>		14. MOTHER'S MAIDEN NAME <u>Almaire Hurley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>218-16-6107</u>	
17. INFORMANT <u>RECORDS: Eastern Shore State Hospital</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Diabetes Mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hemiplegia, left</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>4</u> days <u>Sev. yrs.</u> <u>Sev. yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 2, 1960</u> , to <u>Sept. 26, 1960</u> , that (I) (we) last saw the deceased alive on <u>Sept. 25, 1960</u> , and that death occurred at <u>200</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>Simon Virkutis</u> M.D.		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u>Simon Virkutis</u>		22d. ADDRESS <u>Eastern Shore State Hospital, Cambridge, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/27/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Vienna</u>		23d. LOCATION (City, town, or county) (State) <u>Vienna Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u> </u>		25a. REC'D BY REGISTRAR DATE <u>SEP 29 '60</u>	
ADDRESS <u> </u>		25b. REGISTRAR'S SIGNATURE <u>C. L. F. F. F.</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

10246

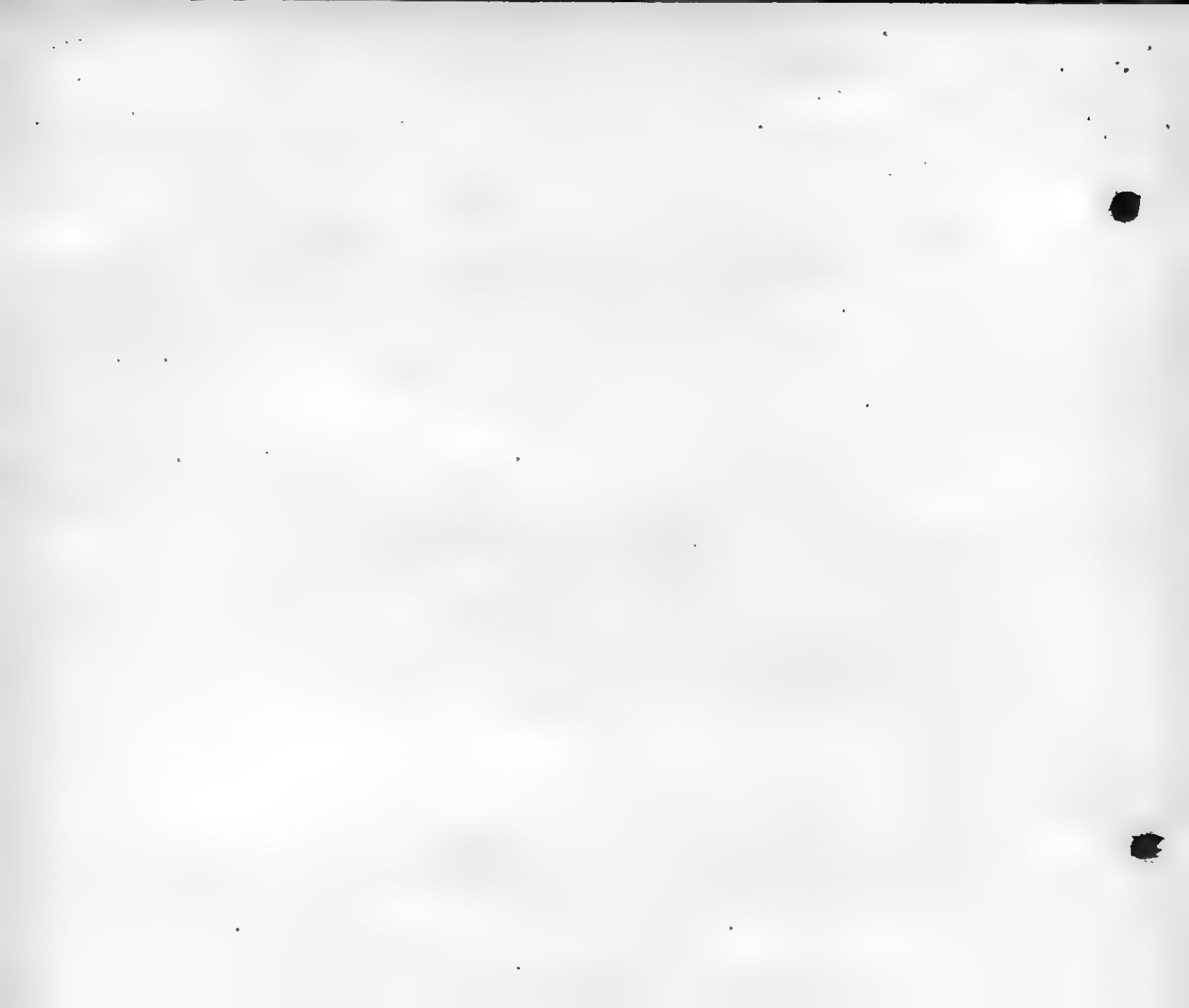
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10215

1. PLACE OF DEATH a. COUNTY <u>Dorchester, Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester, Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sewards, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sewards, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mollie</u> Middle <u>A</u> Last <u>Insley</u>		4. DATE OF DEATH Month <u>9</u> Day <u>12</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/23/1871</u>
9. AGE (In years lost birthday) <u>89</u> yrs		IF UNDER 1 YEAR: Months <u>9</u> Days <u>12</u> Hours <u>19</u> Min. <u>60</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Abbott</u>		14. MOTHER'S MAIDEN NAME <u>Susan Elliott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mrs. Nettie Insley, Swards, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Arteriosclerosis</u> DUE TO <u>Senility</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY: Month, Day, Year Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/10</u> to <u>9/12</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>9/12</u> , 19 <u>60</u> and that death occurred at <u>Ma</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>W. H. HANIKS</u>		22b. PHYSICIAN'S NAME (Type) <u>W. H. HANIKS</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. H. HANIKS</u>		22d. ADDRESS <u>CAMBRIDGE Ma</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/15/1960.</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Family Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Sewards, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Hambridge, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 22 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Walter L. Hanks</u>		25c. DATE	



10247

CERTIFICATE OF DEATH

Reg. Dist. No.

10216

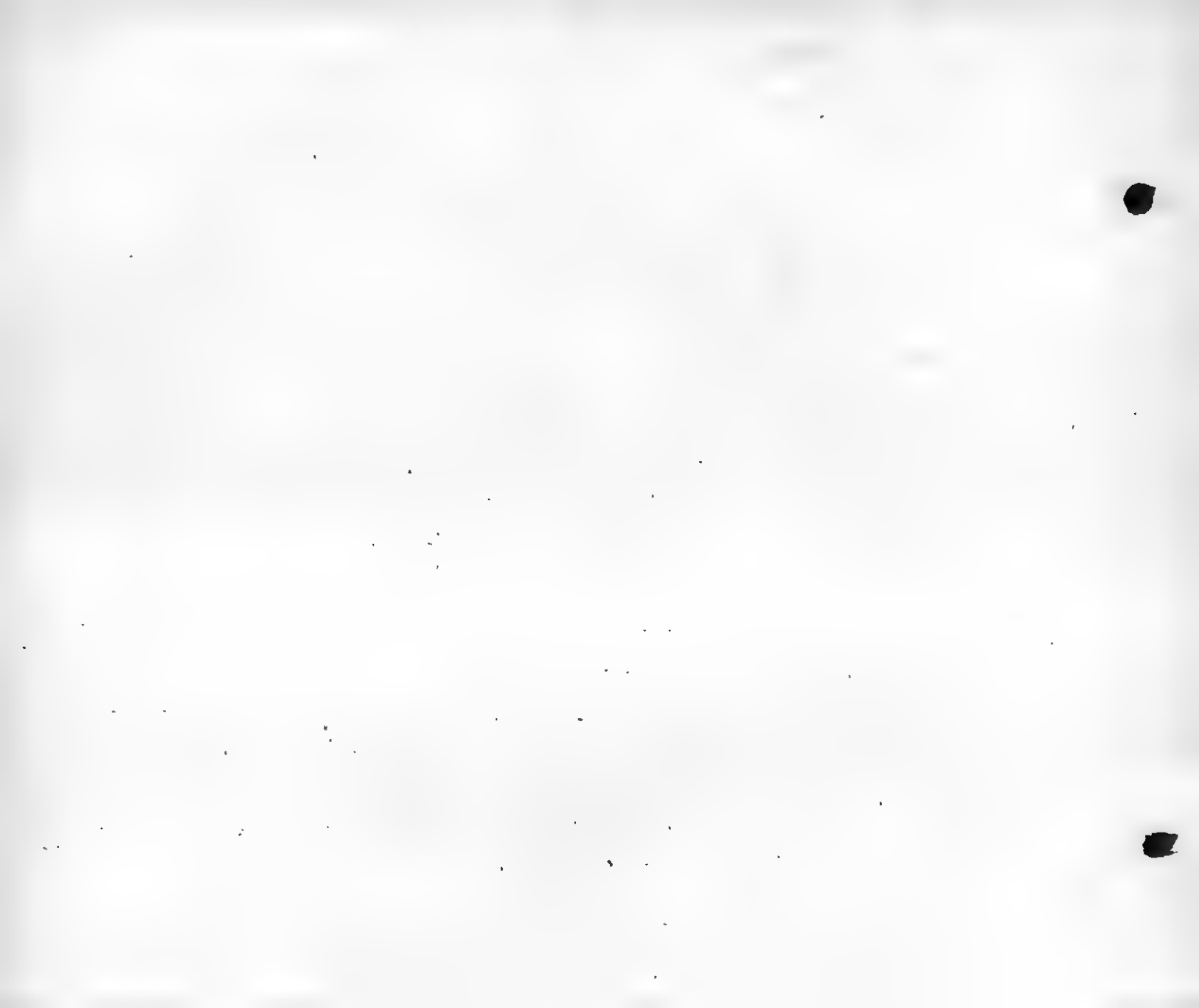
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna - Rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna - Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Rhodesdale				d. STREET ADDRESS Near Rhodesdale		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Wilmer Middle Roy Last Jackson				4. DATE OF DEATH Month September Day 1 Year 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 27, 1895	
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 6 Days 8 Hours 0 Min.		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Daniel Jackson				14. MOTHER'S MAIDEN NAME Jane Cephas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO 41-12-5488		INFORMANT Address Mrs. Willi Jackson, Vienna, Md., R.T.D.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 157 IMMEDIATE CAUSE (a) Generalized metastasis of Carcinoma DUE TO (b) Carcinoma of Pancreas Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 8 months				INTERVAL BETWEEN ONSET AND DEATH 6 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 14, 1960 to Sept. 1, 1960 that I last saw the deceased alive on September 1, 1960 and that death occurred at 11:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE JASON F. & YEE, MD.				ADDRESS (Street, city or town, state) HURLOCK Maryland			
PHYSICIAN'S NAME (Type)				DATE SIGNED 9/6/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 4, 1960		22c. NAME OF CEMETERY OR CREMATORY Rhodesdale Cemetery		22d. LOCATION (City, town, or county) (State) Rhodesdale, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalburg, Maryland				24a. REC'D BY REGISTRAR DATE SEP 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all other papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10230 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10217

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN life <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>200 Phillips St.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> d. STREET ADDRESS <u>200 Phillips St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Richard</u> Last <u>Kane</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 15, 1884</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u> Hours <u>15</u> Min. <u>0</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Labor</u>	
11c. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Kane</u>		14. MOTHER'S MAIDEN NAME <u>Emily Kane</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO <u>520-1</u>	
17. INFORMANT <u>Emory Kane, Cambridge, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>DUE TO</u> (c) <u>DUE TO</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Instant</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
21. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		21. ASS STANT MEDICAL EXAMINER <input type="checkbox"/>	
21. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>John Mace Jr. M.D.</u>		21. DATE SIGNED <u>9/30/60</u>	
21. Address (Street, city, town, or county)		21. Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/1/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Harrisville Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Dorchester Co. Md.</u>	
23. FUNERAL DIRECTOR <u>Herbert M. StClair</u>		23. ADDRESS <u>Cambridge, Md.</u>	
24a. REC'D BY REGISTRAR <u>OCT 4, '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 42 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

M

1

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b entire life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge-Maryland Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS 801 Maryland Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Dorothy Weedon Kelly		4. DATE OF DEATH September 11, 1960 Month Day Year		9. AGE (In years, last birthday) 38 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cambridge			
13. FATHER'S NAME Howard R. Weedone		14. MOTHER'S MAIDEN NAME Louise Lake		12. CITIZEN OF WHAT COUNTRY? U.S.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Charles W. Kelly, 801 Maryland Ave., Cambridge Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Intracranial injury Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (b) Compound fractures skull DUE TO (c) 20 min. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: 20 min.							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was thrown from car which was struck by another car.							
20c. TIME OF INJURY Month, Day, Year 1:30 a.m. 9/11/60		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Water St. Cambridge, Dor., Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John Mace Jr.		M.D. John Mace Jr. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John Mace Jr. M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 9/13/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 13, 1960		22c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park Cambridge, Md.			
23. FUNERAL DIRECTOR Kenneth R. Thomas		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR SEP 20 '60			
				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

10231 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10218

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

10248 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10219

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY in 1b 7yr. 5mo. 29da.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eastern Shore State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary	First Ann Middle Loird	4. DATE OF DEATH Month September Day 8 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-22-85
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR: Months 75 Days 75 Hours 75 Mins. 75	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY -	
12. BIRTHPLACE (State or foreign country) Maryland		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME George W. Turner		15. MOTHER'S MAIDEN NAME Clementine Dize	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		17. SOCIAL SECURITY NO. -	
18. INFORMANT Records - / Eastern Shore State Hospital		Address Eastern Shore State Hospital	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (b) - (a), stating the underlying cause last, (c) - DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture neck r. femur.		INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on floor	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 6:50 PM m. 11-11-59 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Cambridge Dor. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Maco Jr.		M.D. DATE SIGNED 9/8/60	
EXAMINER'S NAME (Type) John Maco Jr.		Address (Street, city, town, or county) CRISFIELD, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-10-60	
22c. NAME OF CEMETERY OR CREMATORY SUNNYRIDGE CEMETERY		22d. LOCATION (City, town, or country) (State) CRISFIELD, MD.	
23. FUNERAL DIRECTOR BRADSHAW & SONS		24a. REC'D BY REGISTRAR SEP 14 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

MEDICAL CERTIFICATION

10245

CERTIFICATE OF DEATH

10213

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admision) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Le Compte Funeral Service</u>				d. STREET ADDRESS <u>10245</u>		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Lee</u> Last <u>Dean</u>				4. DATE OF DEATH Month <u>10</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/1/1914</u>	9. AGE (In years last birthday) yrs <u>46</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>2</u>		IF UNDER 24 HRS Hours <u>12</u> Min <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>John Dean</u>				14. MOTHER'S MAIDEN NAME <u>Melissa Dean</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mrs Mildred Runk Fishing Creek</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>7324</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Old age (degenerative)</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>—</u>					
20c. TIME OF INJURY Month <u>—</u> Day <u>—</u> Year <u>19</u> Hour a. m. <u>—</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I attended the deceased from <u>Mar 19 58</u> to <u>Sept 29 1960</u> that I last saw the deceased alive on <u>Sept 29 1960</u> and that death occurred at <u>5:00</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>—</u> DATE SIGNED <u>—</u>							
ACTUAL SIGNATURE <u>Maurice I. Shub</u> M.D. <u>Fishing Creek</u>							
PHYSICIAN'S NAME (Type) <u>Maurice I. Shub</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/2/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hosier Memorial Church</u>		22d. LOCATION (City, town, or county) (State) <u>Fishing Creek, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Maryland.</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

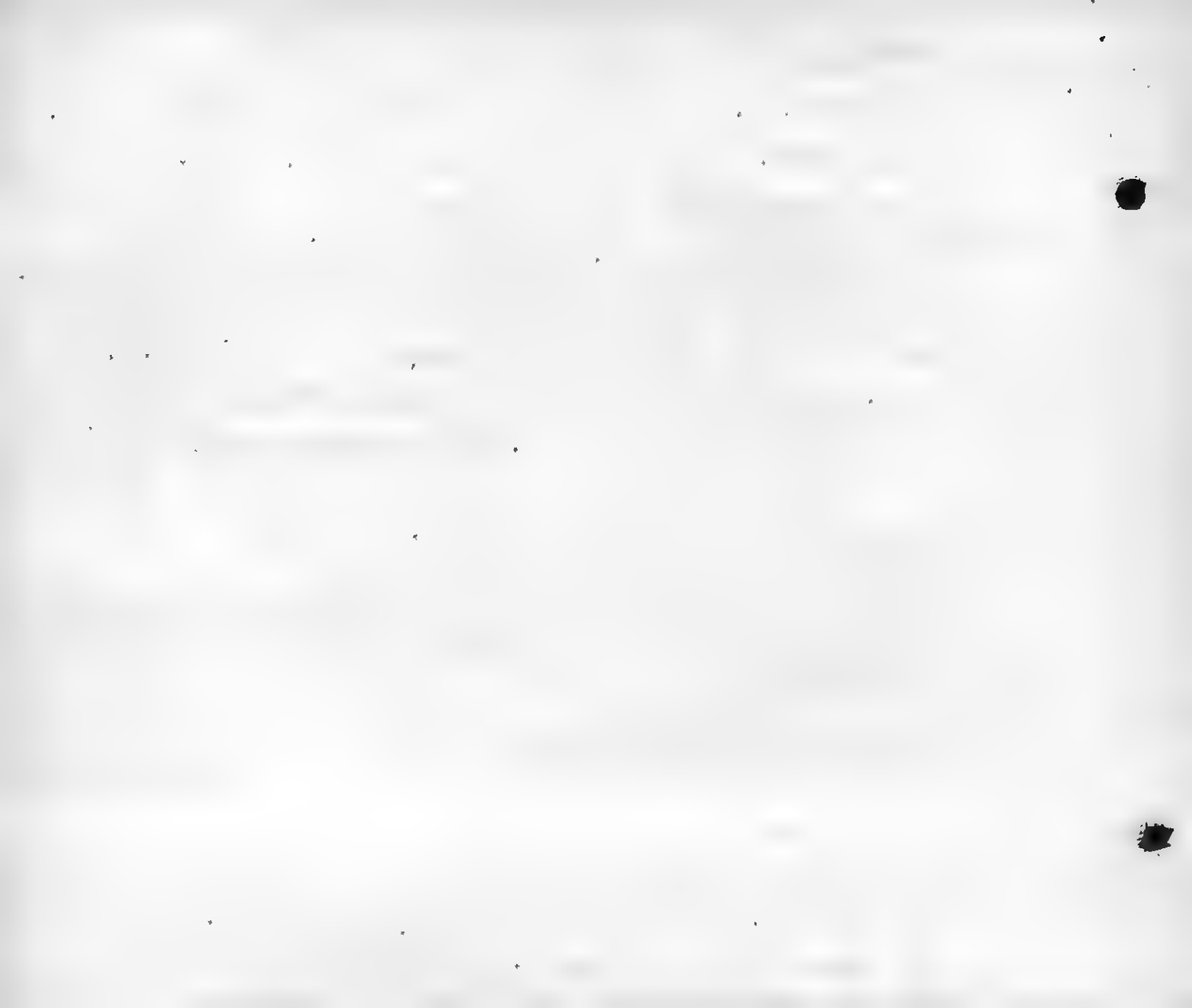


TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/5

1
10232
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
10220

1 PLACE OF DEATH a. COUNTY Dorchester, Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Res dence before adm sion) a. STATE Maryland b. COUNTY Dorchester, Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland.		c. LENGTH OF STAY IN 1b 1 Week	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hudson, Maryland.		d. STREET ADDRESS None	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle A. Last Mowbray		4. DATE OF DEATH Month 9 Day 5 Year 1960	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/6/1923
9 AGE (In years last birthday) 37 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Painter	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James P. Mowbray		14. MOTHER'S MAIDEN NAME Olevia Harrington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mr. James Mowbray, 901 Roslyn, Ave, Cambridge Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 157X Carcinoma Pancreos DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 5 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/10 1960 to 9/5 1960 that (I) (we) last saw the deceased alive on 9/5 1960 and that death occurred at 5 P.M. from the causes and on the date stated above.			
22a. SIGNATURE W. H. Hanks		22b. DATE SIGNED 9/6/60	
22c. PHYSICIAN'S NAME (Type) W. H. HANKS		22d. ADDRESS CAMBRIDGE - MARYLAND	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/8/1960.	
23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park.		23d. LOCATION (City, town, or county) (State) Cambridge, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.		25a. REC'D BY REGISTRAR DATE SEP 22 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanks			



CERTIFICATE OF DEATH

10221

Reg. Dist. No.

10249

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u>		2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) b. STATE <u>MARYLAND</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DORCHESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>		c. LENGTH OF STAY IN 1b <u>4 1/2 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSPITAL</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY IRENE MURPHY</u>		4. DATE OF DEATH Month Day Year <u>SEPTEMBER 4 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DECEMBER 14 1894</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State of foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>HOSPITAL RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>332X</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APR. 25, 1957</u> to <u>SEPT. 4, 1960</u> , that I last saw the deceased alive on <u>SEPT. 3, 1960</u> , and that death occurred at <u>1:30</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Harry J Crawford</u> M.D. <u>CAMBRIDGE, MARYLAND</u> <u>SEPT 4, 1960</u>			
PHYSICIAN'S NAME (Type) <u>HARRY J CRAWFORD</u> Good Counsel Churchyard			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/6/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>L.G.C. SECRETARY</u>	22d. LOCATION (City, town, or county) (State) <u>Secretary M.D.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth R. Thomas</u> ADDRESS <u>100 Locust St.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 8 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10250

10222

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN <u>MD</u> <u>8 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Eastern Shore State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u> d. STREET ADDRESS <u>Box 364</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lula Wharton Parks</u>		4. DATE OF DEATH <u>September 20 1960</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-19-81</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR: Months <u>78</u> Days <u>78</u> Hours <u>78</u> Min. <u>78</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Frank Tull</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown Mary Godwin</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service) <u>---</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Eastern Shore State Hospital Records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u> DUE TO <u>---</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>---</u> DUE TO <u>---</u> (c) <u>---</u>		INTERVAL BETWEEN ONSET AND DEATH <u>---</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>---</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>---</u> p.m. <u>---</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. (City or town) <u>---</u> (County) <u>---</u> (State) <u>---</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John L.ace Jr.</u>		DATE SIGNED <u>9/23/60</u>	
EXAMINER'S NAME (Type) <u>John L.ace Jr.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-24-60</u>	
22c. NAME OF CEMETERY <u>First Baptist</u>		22d. LOCATION (City, town, or country) <u>Pocomoke City, Maryland</u>	
23. FUNERAL DIRECTOR <u>Henry H. Watson</u>		24a. REC'D BY REGISTRAR <u>SEP 26 '60</u>	
ADDRESS <u>Pocomoke City, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MEDICAL CERTIFICATION

10223

1. PLACE OF DEATH a. COUNTY Dorchester, Co.		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.		c. LENGTH OF STAY IN TB 1 Week		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY Dorchester, Co.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS None		4. DATE OF DEATH Month 9 Day 20 Year 1960		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/26/1896		9. AGE (In years lost birthday) yrs 64		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Waterman		11. BIRTHPLACE (State or foreign country) Wingate, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME J. Elbridge Pritchett	
14. MOTHER'S MAIDEN NAME Martha V. Todd		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 220-15-9863		17. INFORMANT Mrs. Mildred Pritchett, Wingate, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 416X DUE TO Myocardial Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO (c) Rheumatic Fever		INTERVAL BETWEEN ONSET AND DEATH 6 days		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aneurysm Aorta		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 9/14 to 9/20 , 19 60 that (I) (we) last saw the deceased alive on 9/20 , 19 60 , and that death occurred 7:24 PM from the causes and on the date stated above.		22a. SIGNATURE W. H. Hanks		22b. DATE 9/21/60		22c. PHYSICIAN'S NAME (Type) W. H. HANKS, M.D.	
22d. ADDRESS CAMBRIDGE, MARYLAND		23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 9/22/1960.		23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		23d. LOCATION (City, town, or county) (State) Cambridge, Maryland.	
24. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.		25a. REC'D BY REGISTRAR SEP 29 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hume					



10251

CERTIFICATE OF DEATH

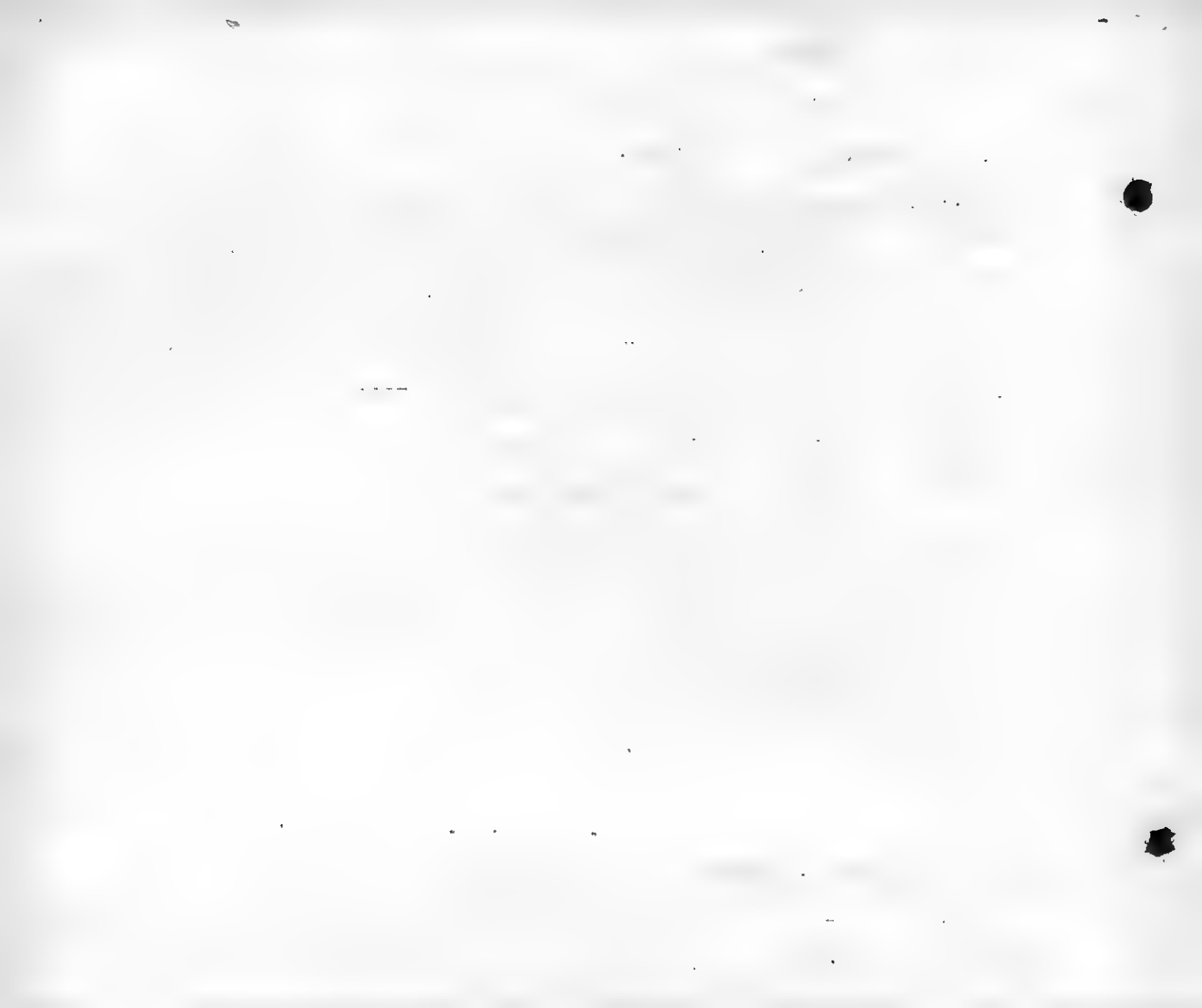
10224

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge				c. LENGTH OF STAY IN 1b 4 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				d. STREET ADDRESS 900 Walnut Street			
3. NAME OF DECEASED (Type or print) First ERIN Middle SUSAN Last REVELL				4. DATE OF DEATH Month Sept. Day 26 Year 19 60			
5 SEX female		6. COLOR OR RACE white		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/14/74	
9 AGE (In years last birthday) 85 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Virginia	
12 CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Jesse Powers				14. MOTHER'S MAIDEN NAME Susan Stokes Stakes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		INFORMANT Hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 260X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) Diabetes Mellitus DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 3/15 , 19 56 to 9/26 , 19 60 that I last saw the deceased alive on 9/26 , 19 60 , and that death occurred at 10:50a , from the causes and on the date stated above				ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Thomas J. Dredge M.D.				E.S. Hospital, Cambridge, Md. 9/26/60			
PHYSICIAN'S NAME (Type) Thomas J. Dredge							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-28-60		22c. NAME OF CEMETERY Downing Cemetery		22d. LOCATION (City, town, or county) (State) Oak Hall, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert N. Watson				ADDRESS Pocomoke City, Md.		24a. REC'D BY REGISTRAR DATE SEP 29 '60	
				24b. REGISTRAR'S SIGNATURE Orlough S. Kraus			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

10252

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY KENT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. LENGTH OF STAY IN 1b 3 YEARS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL, GOLTS		d. STREET ADDRESS RFD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTERN SHORE STATE HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KATIE S. Middle ROSIN Last		4. DATE OF DEATH Month SEPT. Day 1 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 6, 1878
9. AGE (In years lost birthday) 81 yrs.		10. IF UNDER 1 YEAR: Months 8 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN PAUL SMITH		14. MOTHER'S MAIDEN NAME SARAH CATHERINE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT HOSPITAL RECORD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CHRONIC CARDIOVASCULAR DISEASE DUE TO GENERALIZED ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Interval between onset and death	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY 22 , 19 57 to SEPT. 1 , 19 60 , that I lost the deceased alive on SEPT. 1 , 19 60 , and that death occurred at 1020 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Ettore De Filippis M.D. EASTERN SHORE STATE HOSP.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT. 5, 1960	
22c. NAME OF CEMETERY OR CREMATORY GALENA CEM.		22d. LOCATION (City, town, or county) (State) GALENA, KENT CO., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles DeLeon		24a. REC'D BY REGISTRAR DATE SEP 6 '60	
24b. REGISTRAR'S SIGNATURE Charles S. Hume			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

10234

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10226

1 PLACE OF DEATH a COUNTY <u>Dorchester, Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a STATE <u>Maryland.</u> b COUNTY <u>Dorchester, Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u>		c LENGTH OF STAY IN TB <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home Cambridge Md, Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Tilden</u> Middle <u>W.</u> Last <u>Rue</u>		4. DATE OF DEATH Month <u>9</u> Day <u>7</u> Year <u>1960</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3/15/1877</u>
9 AGE (In years last birthday) yrs <u>83</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Rue</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Roe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Frances J. Rue, Cambridge, Md.</u>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>hypertension</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-3</u> <u>1960</u> , to <u>9-7</u> <u>1960</u> , that (I) (we) lost saw the deceased alive on <u>9-7</u> <u>1960</u> , and that death occurred at <u>3:30</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>2223</u>		22b. DATE SIGNED <u>9-9-60</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>9/10/1960</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		23d LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Md.</u>		25a REC'D BY REGISTRAR DATE <u>SEP 22 '60</u>	
25b REGISTRAR'S SIGNATURE <u>Charles E. Kraus</u>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE HEALTH DEPT.



1

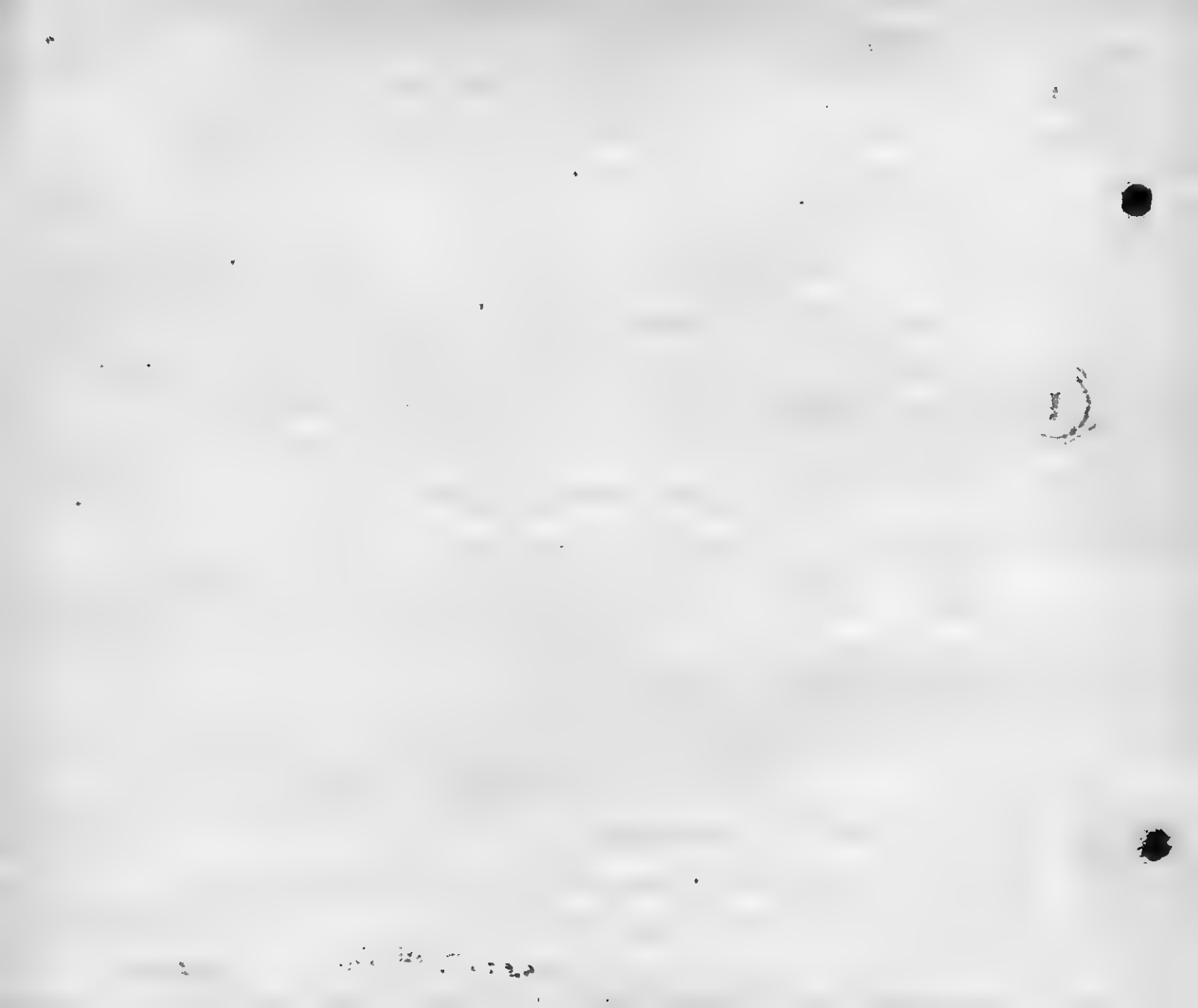
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10235 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10227

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN 1b <u>2 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Secretary</u> d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Elizabeth Saunders</u> First Middle Last		4. DATE OF DEATH Month Day Year <u>Sept. 27 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 2, 1906</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	9. AGE (In years last birthday) <u>63</u> yrs
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Hoosick</u>		14. MOTHER'S MAIDEN NAME <u>Annie Whiteley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Records Cambridge Hospital</u>	
17. INFORMANT <u>Records Cambridge Hospital</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> DUE TO Complications if any, which gave rise to immediate cause (b) <u>Hypertensive C-V Disease</u> (a), stating the underlying cause - last (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I; 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Maca Jr.</u> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/27/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		22d. LOCATION (City, town, or country) (State) <u>East New Market, Md</u>	
23. FUNERAL DIRECTOR <u>Laith's Pulling Co. N. Market</u> ADDRESS		24a. REC'D BY REGISTRAR <u>SEP 29 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10253

CERTIFICATE OF DEATH

Reg. Dist. No.

10228

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY North East	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b 9/12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Ida Middle B Last SETH		4. DATE OF DEATH Month Sept Day 18 Year 1960	
5. SEX F	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 12-1880
9. AGE (In years last birthday) 80 yrs		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard T. Howard		14. MOTHER'S MAIDEN NAME Emma Fox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Hospital records		Address Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 199.1 IMMEDIATE CAUSE (a) Abdominal Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH UNK	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1 , 1953, to Sept 18 , 1960, that I last saw the deceased alive on Sept 18 , 1960, and that death occurred at 8:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas J. Dredge		ADDRESS (Street, city or town, state) E.S.S. Hospital, Cambridge, Md.	
PHYSICIAN'S NAME (Type) Thomas J. Dredge		DATE SIGNED 9-18-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-22-60	22c. NAME OF CEMETERY OR CREMATORY UNION METHODIST	22d. LOCATION (City, town, or county) (State) North East Rural Md
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		24a. REC'D BY REGISTRAR DATE SEP 21 '60	
ADDRESS North East, Md		24b. REGISTRAR'S SIGNATURE Arthur B. Grant	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

10254

1
BALTIMORE STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10229

1. PLACE OF DEATH a. COUNTY <u>Dorchester, Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester, Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md. (R.F.D.)</u>		c. LENGTH OF STAY IN 1b <u>5 Days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Maryland. (R.F.D.)</u>		d. STREET ADDRESS <u>None</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alexander</u> Middle <u>Seward</u> Last <u>#</u>		4. DATE OF DEATH Month <u>9</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/5/1870</u>
9. AGE (In years last birthday) <u>90</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USULA OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Waterman</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland, Dorchester, Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander Seward</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Wheatley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>J. Norman Seward, Cambridge, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> DUE TO <u>450.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Embolus femoral artery</u> DUE TO <u> </u> (c) <u>Generalized arteriosclerosis</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 minutes</u> <u>4 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u>19</u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/26</u> , 19 <u>60</u> to <u>10/1</u> , 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>10/1</u> , 19 <u>60</u> and that death occurred at <u>5P</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. ADDRESS <u>CAMBRIDGE Md</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. H. HANKS</u>		22d. DATE SIGNED <u>10/1/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/2/1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Spedden Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Cambridge, Md. R.F.D. # 3</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 5 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10255 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10231

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before adm. ss. opt.) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY in lb 9 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital		d. STREET ADDRESS Chance	
3. NAME OF DECEASED (Type or print) First Carrie Middle Smallwood Last --		4. DATE OF DEATH September 19 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-19-91
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) --		16. SOCIAL SECURITY NO. --	
17. INFORMANT Eastern Shore State Hospital records		Address --	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 42-0-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. -- DUE TO -- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) --		INTERVAL BETWEEN ONSET AND DEATH Instant	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --		20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --	
20f. (City or town) -- (County) -- (State) --		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
21. ACTUAL SIGNATURE John Mace Jr. M.D.		21. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS. STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
21. EXAMINER'S NAME (Type) John Mace Jr.		21. DATE SIGNED 9/19/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-22-60	
22c. NAME OF CEMETERY OR CREMATORY ROCKCREEK METHODIST		22d. LOCATION (City, town, or country) CHANCE (State) MD	
23. FUNERAL DIRECTOR L. S. Webster Sea Island Snd		24a. REC'D BY REGISTRAR SEP 26 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

MEDICAL CERTIFICATION

10256

CERTIFICATE OF DEATH

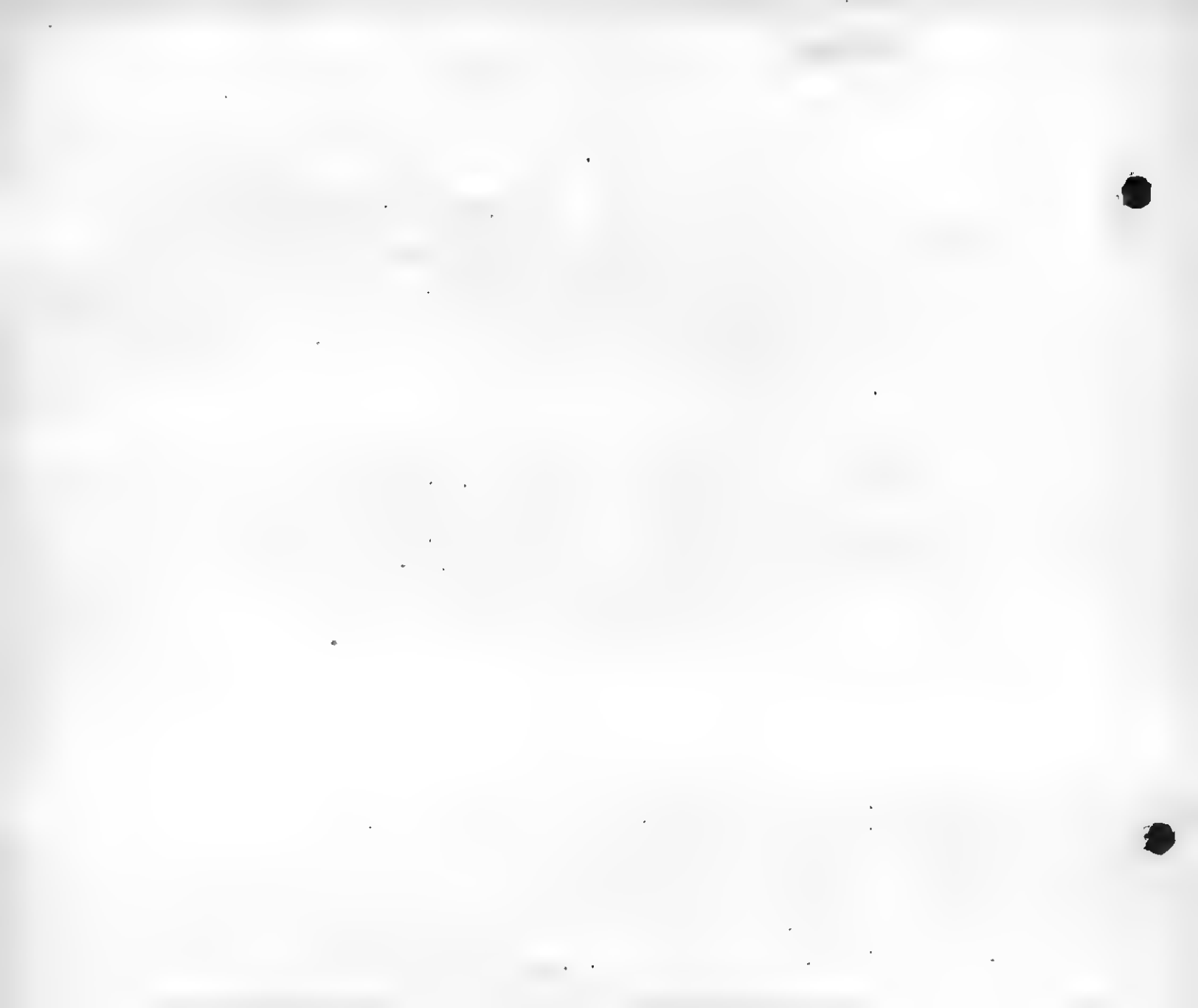
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HURLOCK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>E. S. S. Hospital</u>				e. STREET ADDRESS <u>Wagon & ...</u>			
3. NAME OF DECEASED (Type or print) First <u>Lee</u> Middle <u>Houston</u> Last <u>Stevens</u>				4. DATE OF DEATH Month <u>September</u> Day <u>12</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/10/1886</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Shadrach Stevens</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Wright</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		INFORMANT <u>Hospital Records</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General arteriosclerosis with C.V. D.</u> DUE TO (b) <u>adenocarcinoma recti</u> DUE TO (c) <u>Diabetes Mellitus</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last						INTERVAL BETWEEN ONSET AND DEATH <u>Seven yrs.</u> <u> </u> <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chron. Brain synd. associat. with Cereb. arterioscl. with By</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/24</u> , 19 <u>60</u> , to <u>Sept. 12</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Sept. 12</u> , 19 <u>60</u> , and that death occurred at <u>8:20 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Simon Vircutis</u> M.D.				ADDRESS (Street, city or town, state) <u>Cambridge, Md.</u> DATE SIGNED <u>Sept. 12, 1960</u>			
PHYSICIAN'S NAME (Type) <u>Simon Vircutis</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Sept 15, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>E. New Market Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>E. New Market Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold W. ...</u> ADDRESS <u>Federalburg, Md.</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>SEP 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL—ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10236

10234

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Hosp</u>				d. STREET ADDRESS <u>227 Pine St</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Henry Thomas</u>				4. DATE OF DEATH Month <u>9</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/16/82</u>	9. AGE (in years last birthday) <u>78</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Jane Thomas</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>W. C. Thomas</u> Address <u>St. Paul, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Hemorrhage</u> <u>331X</u> DUE TO (b) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia</u>							19. WAS A POSTMORTEM PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 4, 1960</u> to <u>Sept 18 1960</u> , that (I) (we) last saw the deceased alive on <u>Sept 18 1960</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>J. Edwin Fassett</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>Sept 20-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>				22d. ADDRESS <u>227 Pine St-Cambridge, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burn</u>		23b. DATE THEREOF <u>9/21/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Thomas Memorial Cem</u>		23d. LOCATION (City, town, or county) (State) <u>St. Michaels, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James S. Smith</u> ADDRESS <u>Boston, Md.</u>				25a. REC'D BY REG. STRAR <u>SEP 26 '60</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MEDICAL CERTIFICATION

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10257

CERTIFICATE OF DEATH

10235

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE Maryland b. COUNTY Queen Anne ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chester	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS 17	
3. NAME OF DECEASED (Type or print) First Sarah Middle Elizabeth Last Thomas		4. DATE OF DEATH Month September Day 27 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-6-83
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR: Months 77 Days 77 Hours 77 Min. 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Thomas		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -	
INFORMANT Address RECORDS - Eastern Shore State Hospital			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral Hemorrhage 331 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 3 , 19 60 , to Septem. 27 , 19 60 , that I last saw the deceased alive on Sept. 27 , 19 60 , and that death occurred at 4 A. M., from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED Ettore De Filippis M.D. E.S.S. Hospital, Cambridge, Md. 9-27-60			
ACTUAL SIGNATURE Ettore De Filippis			
PHYSICIAN'S NAME (Type) Ettore DeFilippis			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Sept 29, 60	22c. NAME OF CEMETERY OR CREMATORY Stevensville Md	22d. LOCATION (City, town, or county) (State) Stevensville Md
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L Lane		24a. REC'D BY REGISTRAR 4 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Hume

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10237

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10236

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN TB <u>5 Days</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Maryland Hosp.</u>				d. STREET ADDRESS <u>1</u>					
3. NAME OF DECEASED (Type or print) First <u>Lorrie</u> Middle <u>Francine</u> Last <u>Tyler</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>12</u> Year <u>19 60</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 13, 1956</u>			
9. AGE (In years lost birthday) <u>4</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>12</u> Hours <u>19</u> Min.		IF UNDER 24 HRS. Months <u>4</u> Days <u>12</u> Hours <u>19</u> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME <u>Kennith Tyler</u>				14. MOTHER'S MAIDEN NAME <u>Lorraine Lawson</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Kennith Tyler Honga Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>340.1</u> DUE TO <u>Meningoencephalitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Pneumonia</u> DUE TO (c) <u></u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>9-9</u> 19 <u>60</u> to <u>9-12</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>9-12</u> 19 <u>60</u> and that death occurred at <u>12</u> M. from the causes and on the date stated above.									
22a. SIGNATURE <u>Wilbur N. Baumann</u>				22b. DATE SIGNED <u>9-12-60</u>					
22c. PHYSICIAN'S NAME (Type) <u>Wilbur N. Baumann</u>				22d. ADDRESS <u>Cambridge Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 14, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Cambridge Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service</u>				ADDRESS <u>Cambridge Maryland</u>		25a. REC'D BY REGISTRAR <u>SEP 22 '60</u>			
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10238

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near East New Market		c. LENGTH OF STAY IN 1b 5 Min.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. 16		e. STREET ADDRESS Williamsburg-Hurlock Road	
3. NAME OF DECEASED (Type or print) First Rafe Middle Williams Last Williams		4. DATE OF DEATH Month September Day 23 Year 19 60	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 18, 1904
9. AGE (in years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Morris, Georgia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Mrs. Inell Williams, Hurlock, Md., R.F.D.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial injury DUE TO Conditions, if any, which gave rise to immediate cause (b) Multiple fractures skull. (c) DUE TO (a), stating the underlying cause lost. (c) 			INTERVAL BETWEEN ONSET AND DEATH Instant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car, hit tree and thrown out of car.	
20c. TIME OF INJURY Month, Day, Year 1 A.M. 9-23-19 60	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) (County) (State) Nr. East New Market Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John Mace Jr.		DATE SIGNED 9/24/60	
EXAMINER'S NAME (Type) John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 24, 1960	22c. NAME OF CEMETERY OR CREMATORY Washington Cemetery	22d. LOCATION (City, town, or county) (State) Near Hurlock, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE SEP 27 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Knaus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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